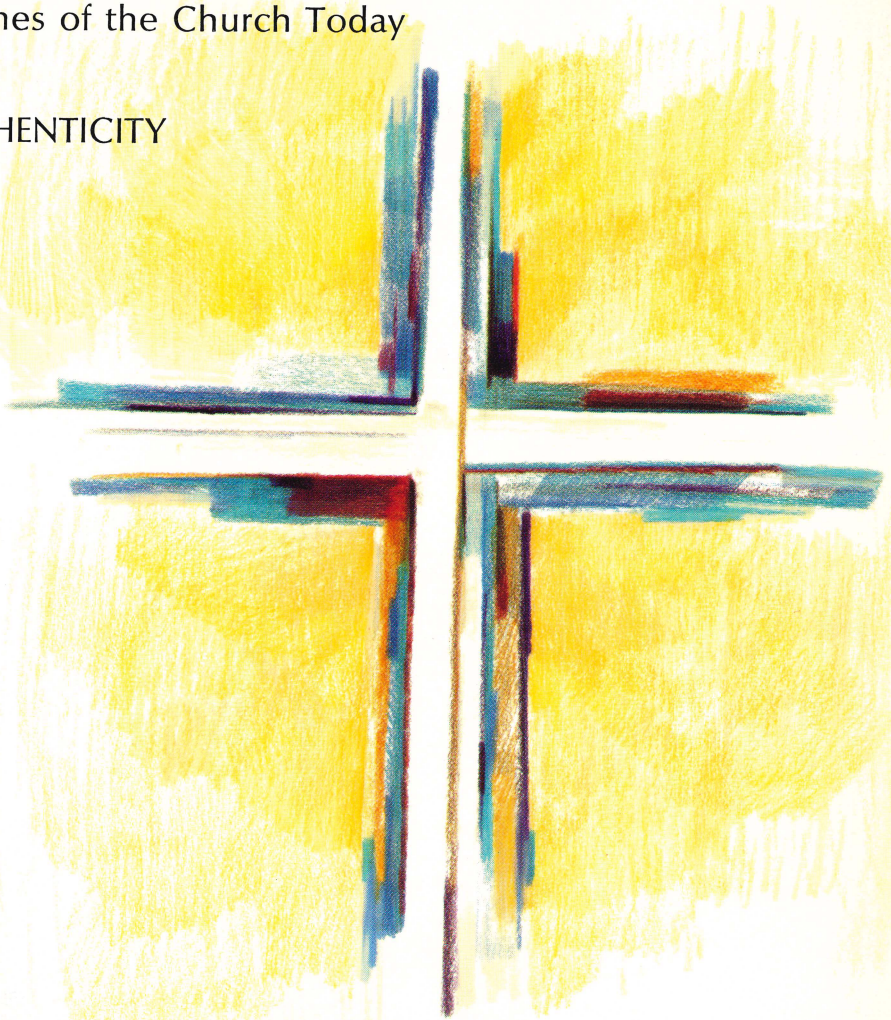
July-August, 1965 MEDICAL MISSIONARY

Themes of the Church Today

IV

AUTHENTICITY



There is a thirst in our day for authenticity.
The Church seeks the fulness of her truth.

To be what she is * valid within and without *
to have the genuine look of her Lord * to do this
day the good He did * to heal and save and teach *
out of the same Love * to realize His Kingdom in
the stuff of this earth * to be available to all
men * to be the Church of the Gospels * of the
Beatitudes * of the poor * to be lowly in spirit *
full of practical concern for men * full of the
spirit of humble, loving, service * full of paschal
joy * to be increasingly, the Bride without spot
or wrinkle * Christ's fulness

REAL and TRUE * HERE and NOW

Sr. M. Lawrence, S.C.M.M.

THE MEDICAL MISSIONARY

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Cover: Student nurses and their instructor, Sister M. Brigetta, in Karachi, West Pakistan, enjoy shopping in the bazaar.

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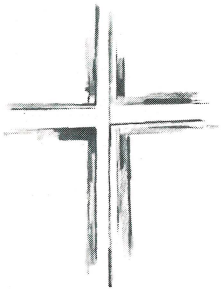
THIS ISSUE...

Authenticity, our theme for July-August, comes down like a great metal arm on our world today, stamping or rejecting each product of our times. Whatever does not ring true, whatever cannot bear the weight of a real test, passes by and is ignored as if it had never come to birth. Probably, for modern men, there is no more despicable label than that of a "phoney," someone or something not true to its claims.

This instinctive sorting of the real from the sham, this constant reaching out to grasp the genuine, is an almost natural reaction after years of being fed a diet of artificial flowers, synthetic clothing, almost-like-homemade pies. People are discovering they have lived too long in a world of imitation knotty-pine offices, simulated alligator shoes and chromium-plated fixtures. Today, they are rejecting with a vengeance anything that substitutes for the real.



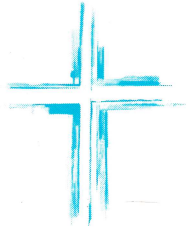
Medical Mission Sisters, by the very nature of our apostolate, have to be authentic. Sickness is a raw thing. It cuts through artificiality and non-essentials. Not just any sort of response can be offered. It jeers at feigned sympathy, unenlightened heroism. Sister M. Claude's diagnosis shows how environment conditions both the need and the Sister's answer to it in her article BENGAL: A CASE HISTORY.

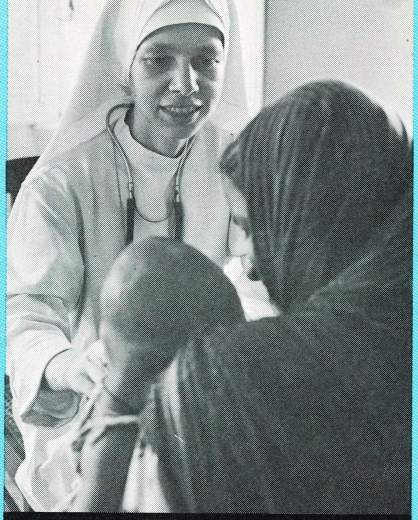
Medical Mission Sisters are usually identified as "hospital Sisters." Our medical teams work within the framework of an institution rather than as isolated medical missionaries. We see these institutions as an authentic answer to medical problems around the world. If Sister M. Lawrence has analysed the situation correctly, our CHRISTIAN INSTITUTIONS hold within them the fullest potential for a genuine contribution on many levels, medical, social and economic.

Only good hospitals, well staffed and well equipped, can offer the young people of new nations the sound preparation they need for their unique role, that of caring for their own people according to modern methods. Sister Miriam Therese presents a survey in photo and copy of some of the Society's

schools of nursing. We find in these schools a valid SOLUTION FROM WITHIN to medical realism in Africa, Asia and Latin America.

Superfluous is not a word one associates with the care of the sick, but rather, one thinks automatically of the essential things, life and death. THAT THEY MAY HAVE LIFE is not only the prayer of a mission hospital staff but, according to Sister M. Pierre's article, the actual challenge the staff faces each day. To meet this challenge with the fullness of a Christian, in a manner learned from Christ Himself, underlines Sister M. Suzanna's IT IS MY PRIVILEGE. These words sum up the sentiments of the MEDICAL MISSION SISTERS in their continued efforts to bring Christ's life to the world.



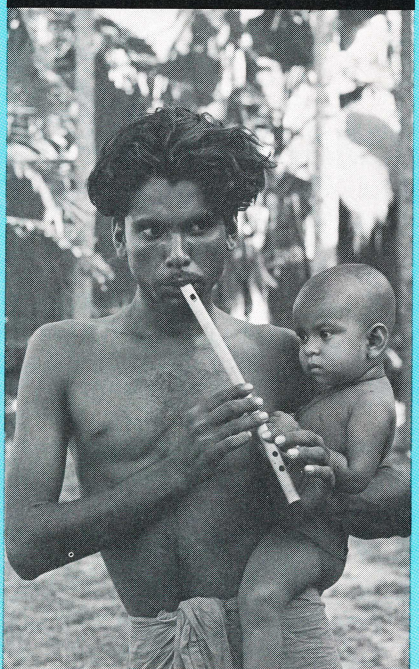


Bengal: case history

BY SISTER M. CLAUDE, M.D.

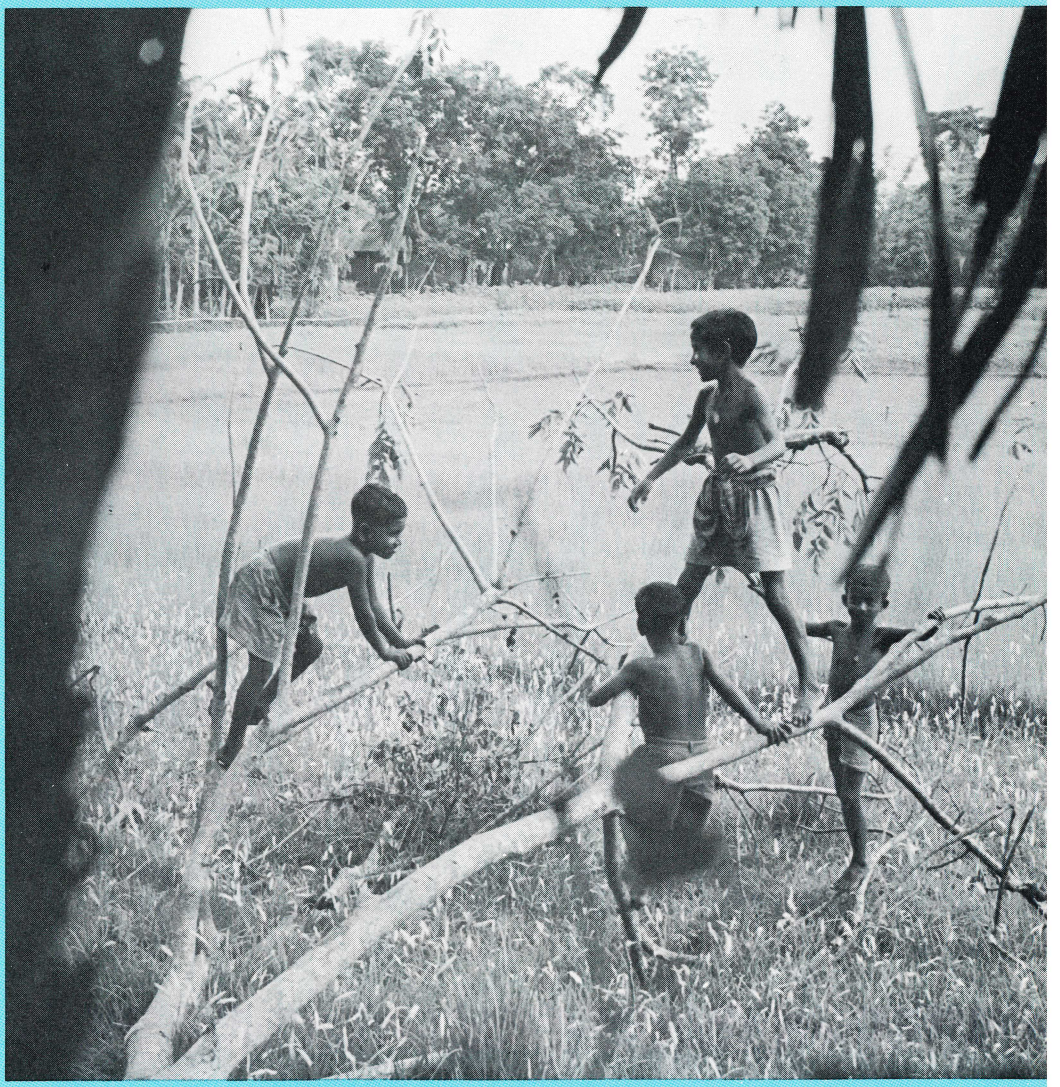
East Bengal has a long case history of physical misery and disease, of ignorance and superstition, although to one who merely skims the surface, it may not appear this way. The casual observer sees only a land traversed by flowing rivers, flat land divided into neat patches of green and golden rice and jute, land dotted with clusters of bamboo huts surrounded by banana and palm trees. East Bengal is a land abounding with children laughing, children catching mud fish in the rain-drenched fields, flying kites and playing games. It is a land where smells of spices and mustard oil fill the evening air; where the jingle of cycle rickshaws, the creaking of wooden-wheeled bullock carts straining under the year's harvest of jute, the brain-fever bird calling "I feel it" are the familiar sounds of lethargic activity which disturb the peace. It is a land in love with music, with tablas, flutes, and singing voices, lissome bodies and dancing feet that translate stories for all to see. It is a land where bargaining puts zest into the daily bazaar, where rapidly changing industrialization and advances in specialized education stand in marked contrast to a primitive, unchanging existence.

Bengal is all this. But to those who have become a part of the



Sister M. Claude, M.D.
(author) is eager to help
this mother and her very sick child.

Bengal abounds with children playing in the fields.



The sound of the flute is so much a part of Bengali culture.

This baby with tetanus is expected to live.

country, there is so much more. Beneath the surface, there are problems. There are people with quick tempers triggered by malnutrition, fatigue and inadequate diets; people surrounded by the stigma of ignorance, superstition and poverty, a deadly trio bent on overpowering the weapons of modern medicine that aim to eradicate sickness and disease. There are the people and their overwhelming needs.

For example, there is Bhulu who is in the hospital now. He looks a great deal like Humpty-Dumpty. Spindly arms and legs protrude from a bulky body cast. His mother brought him in a year ago when the early stages of tuberculosis of the spine were just beginning to deform his back and cause him pain. Medicine and injections were ordered and a cast advised. But Bhulu's mother never returned for these until the disease began to damage the spinal cord and Bhulu could no longer use his legs. She did not know of the paralysis and deformity which result in untreated cases. It was definitely not lack of love which kept Bhulu's mother away. It was simple ignorance.

Then there was Manuel. His disease was the same, but he came from another world. His home was among the hill tribe of Garos living in the north. Friendly and patient, with oriental-like features, he was always ready to smile. Manuel reflected the simple village life of his people.

His father brought him early for treatment and after a few days in the hospital he returned to his home in the Garo hills with a shiny new body cast and a supply of medicines and injections. While all was supposedly going well, Manuel's mother decided the treatment would never cure her son. In the Garo home the woman has the first say, so off with the cast and down to the village doctor for the correct treatment. Manuel made the rounds from village doctor to witch doctor to herbal medicine to needle puncture until the disease progressed to the point where he could no longer sit or walk and even his mother, seeing his thin, pale body, realized that she had done wrong. He arrived at the hospital a second time, this time on a stretcher, but still smiling. We took him in and began again.

Mohammed Ibrahim is a nice old man. One immediately notices his grey-green eyes, a little unusual in this part of the world, and the sparse little goatee just turning grey. He is an average man, a farmer, who in all his fifty years never had the stimulus or opportunity to become literate. He began to work in the fields as a small boy at his father's side, and year after year raised enough rice

and jute to supply his family's wants. His family depended on him. When he finally came to the hospital it was with a long history of pain and discomfort, a story that dates back ten or twelve years to when he first began having upper abdominal pain. At first, it was relieved by medicine, but then it became more constant. For the past three years, he has been unable to eat rice and has been living mostly on milk, coconut water and bread. He has spent much money on medicine and has finally come now for the operation which should have been done ten years ago. His story is repeated daily in the dispensary. Sporadic meals, high-strung temperaments, lack of vitamins, constant intake of chillies and spices make his peptic ulcer one of the most popular surgical diseases in this part of the world.

And then there are the mothers and babies of Bengal. Septic conditions at the time of delivery account for an unknown number of deaths from tetanus neonatorum; fear and attachment to tradition have killed many a young mother. Superstition runs deep and does not easily die. The baby got tetanus because the cow mooed when it was born, they say. Or, the piece of bamboo the village doctor ties on the leg is the best cure for any pain. Cow dung is good for burns; amulets around the neck are good for fever. Shave a small area on top of the head, apply ointment, a leaf, and the cough is sure to go away.

One could relate a whole list of beliefs, but to balance the picture, it is necessary to state that the weapons against disease are also here and constantly increasing. There is chloromycetin for typhoid fever, vaccinations for smallpox and cholera, government programs for tuberculosis and malaria; there are doctors, nurses and technicians, a small group but a growing group; there are facilities for surgery and X-ray. A fair number of free hospitals, medicines and maternity clinics stand in readiness.

East Bengal with its problems and promise calls for love, understanding and a willingness to educate even though results are hard to see. It calls out for authentic Christian care, care given without thought of reward but given with an eagerness to understand and a desire to manifest Christ's own compassion for a people in need.

BLESSED ARE THOSE WHO DIE IN THE LORD ✝

Please pray for our deceased benefactors:

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solution from within

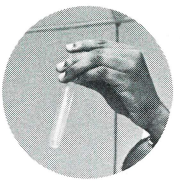
BY SISTER MIRIAM THERESE

One of the most critical problems of the present day is the scarcity of qualified medical personnel to care for the disease-stricken of the world. The need for qualified members in the nursing profession is most acute. For sheer lack of numbers, it is able to make, at best, but a skeletal contribution in areas of overwhelming need. In some areas, there is but one nurse for 2500 people, or one for 4600 or, as in East Pakistan, one nurse for every 100,000 persons. This is not exaggeration, but fact.

We of the West who feel a responsibility for our neighbor's welfare could march across the world in droves, if we cared to do so. We could put our hand to the task and make some small dent in the mass of misery that is strangling those new nations just coming to birth. We could, if we cared to do so. But even if we did, this would not, in itself, be the final answer. We would simply be applying a patch from the outside, be building a temporary solution, a flimsy scaffolding from foreign materials by foreign hands. Such a structure is a good and legitimate contribution, but it is bound to crumble before the onslaught of national progress or fall prey to the ravages of time.

The solution to the problem of who will care for the sick lies within, at the core of individual nations and cultures. It lies with the young women of those nations, many of whom have the potential and, very often, the desire to serve their own. All they need is to be given a chance. Today, our most genuine contribution to any nation is to give them this chance. By training their people for service, we bring those nations one step nearer to their goal. Nations aspiring to independence need to stand on their own two feet. Medical Mission Sisters, by means of their training programs, are helping them to do just that. This type of contribution lacks fanfare. The anxiety and the labor take place behind the scenes. But this gift to a people is permanent and, in the long run, the most fruitful.

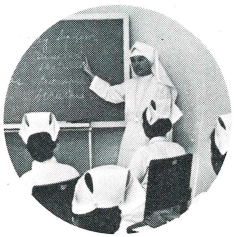
East Pakistan



In East Pakistan there are less than 600 graduate nurses to care for 55 million people. Reasons for this shortage include insufficient education, religious and social barriers, and poor health. Nursing as a profession is just beginning to emerge here. Despite the demand for more nurses, only two girls sat for the final nursing exam in 1964. That means only two new nurses for the whole of East Pakistan. The government offers a stipend to the nursing student in order to encourage more women to enter the profession. This factor of financial security is a real incentive to a young Pakistani. In East Pakistan, Medical Mission Sisters are assisting the nation by turning out nurses of the highest caliber, by working to remove the stigma which plagues the nursing profession, and by seeking to instill within the Pakistani woman the proper qualities and ideals of selfless service.

It's no fun being the center of attention when it hurts so much! This youngster assists Sister M. Nora, R.N., in a demonstration on dressing wounds in Holy Family Hospital, Dacca.

West Pakistan



At the time of partition in 1947, Holy Family Hospital School of Nursing, Rawalpindi, shared in the general atmosphere of upheaval. After things settled down, it began all over again in a new cultural milieu. Since then, the school has graduated hundreds of girls. To prepare Pakistani girls for a life of service is both a privilege and a challenge, for the Islamic woman is only now beginning to emerge from a centuries-old tradition of seclusion. She has religious, social, educational and psychological barriers to overcome. Training Pakistani nurses is an absorbing concern and few realize all that goes into it. But there are moments of triumph, such as on the night of March 31, 1964, at the capping ceremony in Holy Family Hospital, Karachi, when Miss Isani, student nurse, related in her own words the feelings of her class: "We hope to be good, efficient nurses, possessing all the qualities of good nurses, and by our various efforts toward the healing of the sick and teaching the ignorant how to lead a healthy life, to the best of our capability, to keep up the dignity of our profession. We hope to reward our teachers by playing an important part in the good health of our country."

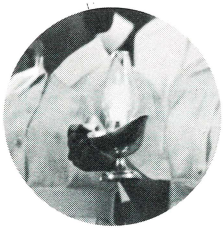
The capping ceremony at Holy Family Hospital, Karachi, is a moment of triumph.

UGANDA

Holy Family Hospital School of Nursing is the only nurses' training school in the whole of western Uganda. Opened in January of 1964, it eagerly awaits its first class of graduates. Before 1964, there were only three training schools in the entire country, all located in the eastern region near the capital city of Kampala. This virtually cancelled all hopes of a nursing career for anyone living in the West. To travel more than 200 miles, to live among a strange tribe in a new environment was almost too much to ask, even though a young woman might sense the acute need of her country and want to do something about it. Since opening day, applicants have not been wanting. Already the young student nurses show great potential. The constant struggle to resolve tribal differences in the face of sickness is a vital aspect of training. Tribal wars are a daily diet all around Fort Portal. The hospital, since it cares for all without discrimination, offers an opportunity for student nurses of different tribes to learn to work together in peace and harmony.

Sister M. Amata, R.N., introduces nursing procedures to her Ugandan students.

GHANA



In Ghana, the nursing profession is not looked down on as it is in many other countries. Education of any kind is a status symbol to the Ghanaian, and for this reason, training schools are deluged with applications. Holy Family Hospital, Berekum, 300 miles inland from the coast, is the only hospital in the entire Brong-Ahafo region having the required departments and services for a nurses' training school. It is the only Catholic nurses' training school in Ghana. Last year, 200 Ghanaian women took the entrance exam, but due to lack of space, the school could accept only 28 in its new class. Besides learning the rudiments of professional care of the sick, student nurses make a valuable contribution by bringing to the hospital staff a deeper insight into the local customs of the villagers. A link between the old and the new, they are particularly helpful when scientific principles come up against granite superstition. In Berekum, the pink starched uniform of the student nurse is symbol of a life dedicated to raising the health standards of a rapidly growing nation.

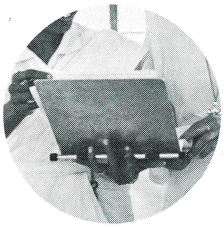
Two Ghanaian student nurses prepare to give injections at Holy Family Hospital, Berekum.

VENEZUELA

Nursing student studying.

Lack of sufficient graduate nurses is Latin America's most critical shortage in health resources. An estimated average of three graduate nurses for every 10,000 people means less than adequate care even in the cities, where most of the nurses inevitably cluster. Surprisingly, there are fewer nurses than doctors in Latin America. The reasons for this phenomenon are clearcut. Lack of adequate training facilities and the low regard in which nursing as a career for women is held are among the chief causes for serious concern. Moreover, a degree in medicine brings status. Nursing does not. Our Lady of Coromoto, the first and only hospital in Venezuela to be completely administered by Sisters, turned its full attention to the nurse crisis in 1963, when it opened its school of nursing. It is the first school in the country to demand as a prerequisite a complete high school education, a practice that is setting a precedent for the nursing profession. As a result, the graduates-to-be are already in demand by several large companies not necessarily associated with the medical profession. Several students are studying under scholarships from these companies and have the security of a future position once their training is complete.

VIETNAM



These two young Vietnamese ladies assure Sister M. Karen that Holy Family Hospital's proposed nursing school will not lack candidates.

As the marginal line of safety crawls steadily southward, the influx of Vietnamese refugees into southern cities continues to reach alarming proportions. Only a handful of nurses is available to cope with the havoc that inevitably follows in the wake of war. The burning questions of the present are, how to ward off wholesale epidemics when entire villages are crammed onto one tiny plot of land? And who will help the miserable and the dying when the inevitable occurs? Holy Family Hospital, Quinhon, is deeply involved in a race against time as its proposed school of nursing creeps to completion. War and lack of supplies called a temporary halt to the building, but it won't be long before Quinhon lays claim to the only nurses' training school within a radius of 260 miles. There are only two nursing schools in the country, one in Saigon, the other in Hué. To date, the Vietnamese government, under the ministry of health, has not yet established the basic requirements, curricula, standards and procedures for a registered nursing program. Although no level of professional competency is demanded by local authorities, the quality of training given at Holy Family Hospital must be of the best. Getting underway as it does while the nursing profession is still in its pioneer stages, it is bound to influence and determine the whole future of nursing in Vietnam. Medical Mission Sisters see this opportunity as an obligation and are eager to begin.

India

North, south, east, west: Medical Mission Sisters' training schools pinpoint the map of India. The contribution of the Sisters to nursing throughout the world reaches its climax in India, where they have labored the longest and reaped the richest results. Since the very beginning of their Society, the Sisters have been struggling to establish the nursing profession in this country and have graduated over 3,000 Indian nurses since 1955. Now after nearly forty years at the task they can look back on the major challenges. It wasn't easy to open a training school without adequate textbooks or to have to translate medical terminology into Hindi script. The training of many Indian Sisters to care for their own people is an important contribution to the Church. The effort to improve the competency of the local *dais* (unskilled midwives) is vital to village life. There are nearly 500,000 villages in India, and less than 1% of the people in these villages are getting professional maternity care. Most significant is their involvement in the Trained Nurses Association of India, established for the purpose of advancing nursing as a profession in India, an organization in which the Sisters take an active part.

Sister M. Eileen, R.N., gives anatomy class a three-dimensional touch at Holy Family Hospital, New Delhi.

at the heart of our work is

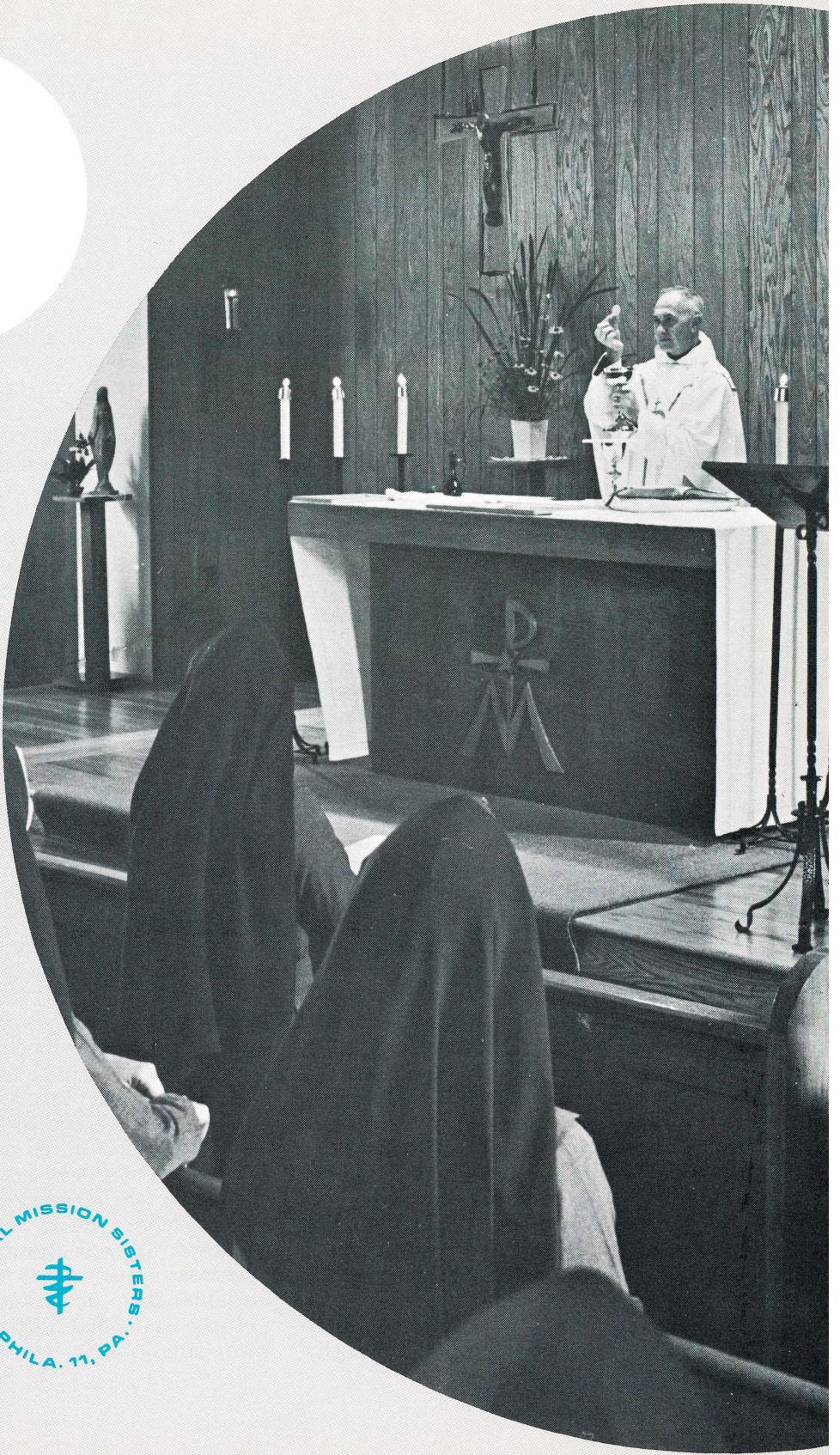
WORSHIP

The liturgy stands at the root and center of the missionary Sister's self-gift to the world. It is the lifestream that invigorates, the essential element, for commitment to Christ begins and ends, builds and bears fruit in the prayer life of His Church. Worship is experience of community in its fullest sense. That communal love which compels the missionary to go out of her own self in the service of others finds its direction in the Mass.

Through the liturgy we, the family of man, praise God our Father with one voice;
with the liturgy we chant the Alleluia victory cry of Mother Church and are charged to bear her healing message—Christ is alive and among us—to all men;
in the liturgy we are all brothers, vitally concerned for one another, filled with one and the same bread, fired to action, replenished, renewed.

The Medical Mission Sister must be solidly grounded in the liturgy and permeated with its spirit. Sent to bear living witness to the Risen Christ, she goes into a world of conflicting ideologies, cultures and beliefs. Her raison d'etre is the word of God which heralds, through her, a genuine response to a 20th-century cry for mercy. Apart from the liturgy, the work of her head and hands would have little meaning. Drawn into it and springing out of it, it becomes Christ's own work and worship. The missionary's daily encounter with Christ and His members around the altar is assurance that her concern for the sick is valid and authentically Christian.

for further information on the vocation of the Medical Missio



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Sisters, write:

Christian

"Institution" is a bad word these days. The current objection is that institutions are big, impersonal, unfeeling. Their image is one that repels. Their demands are grudgingly submitted to as a necessary evil. Within their walls people are subconsciously expected to lose something of their identity, be hurt perhaps, ignored, passed over, dwarfed or left in fear and doubt. The current image is mechanical and distasteful. Need it be so?

For Medical Mission Sisters this is a burning question. Hospitals are an integral element in their conception of realistic medical service. And a hospital is the most complicated of institutions.

By its nature, it abounds in glass and terazza, in machinery, high polish and a smell of antiseptic. This is so disappointingly unromantic: no living in mud huts, no fantastic physical hardships, obvious difficulty in blending in with the scenery. Even the need doesn't look so dramatic, when it is being met. The task of organization is a difficult and absorbing one, and one that is inevitable in a hospital. Why should missionary Sisters put such a mountain of effort into creating hospitals and keeping them going and growing? Would it not be easier and better to conduct simple clinics in simple sheds, to spend one's time and resources visiting village homes and distributing simple remedies?

The problem of health in the underdeveloped countries is complex. Simple answers won't solve it. It takes more than good intentions and simple remedies to serve significantly here. It takes hospitals and all the work that goes into them. The nature of medical science today is such that hospitals, with all the difficulties they present, cannot responsibly be dispensed with. Raising funds, building buildings when this is necessary, finding and training medical personnel, surmounting obstacles of an unimaginably frustrating kind: this is admittedly hard work. But we believe that to do this hard work is an authentic service and a clear call to us. Nothing but this kind of hard work can create health services competent to effect some small but real change for the better in the medical situation.

We are keenly aware that the work of our fast growing number of dispensaries would lack much in depth and long term significance without the backbone of the competent hospitals with which they are linked, out of which they grow, and whose services they extend.

Because hospitals are fundamental to any serious effort at medical service today, we have no real choice in our apostolate between an institutional or non-institutional approach. We work to make available Christian medical institutions in lands where

the positive potential of mission hospitals

INSTITUTIONS

BY SISTER M. LAWRENCE

they are a rare and wonderful thing. We find this a creative and challenging enterprise.

A Christian institution must first of all be a good institution. A good institution is one that achieves its purpose, its great positive potential for really serving *people*. Everything about it is geared to this. A bad institution, on the other hand, succumbs to the temptations to which all institutions are prone: to become a law unto itself, to become preoccupied with its own functioning, and so to become inhuman, stereotyped and dull in responsiveness to the people and environment it was created to serve. Because the love and service of God and men is the inner dynamism of a Christian institution, it must of necessity strive to become a tool of service and not an end in itself. It must reflect the Christian sense of man's dignity and the great value of human life.

"For the honor and glory of God and the cause of suffering humanity." This dedication is written on the cornerstone of one of our Holy Family Hospitals. Every Medical Mission Sister is engaged in the adventure of making this statement a matter of experience for all her patients. It is people that matter to her, and the institution is nothing if it is not a means of expressing her real and deep concern for them. A Christian hospital's only call to existence is Christ's call in that of a sick patient. The many and complex needs of the patient should set the tone for everything. A Christian hospital is a place where humanity calls to humanity and receives a fully human answer in Christ's name.

It is hard to imagine what an awesome thing a hospital is to a simple villager of India or Africa. The big building is both a symbol and an unfamiliar reality. It inspires both hope and fear. To come to a hospital is a great act of trust and one that lays a heavy responsibility on its staff. Great good or great harm can be done to this patient by his stay. He is frightened when he comes, by his lack of strength, his dependence and the unfamiliarity of his situation. His sensitivity is, without a doubt, much heightened because the hospital surroundings are so radically different from what is normal to him. He is keenly perceptive of what goes on around him. His hospitalization could clearly have immense negative repercussions. But it is equally true that the situation, sensitively approached, is a fertile field for enrichment and growth for body and for soul.

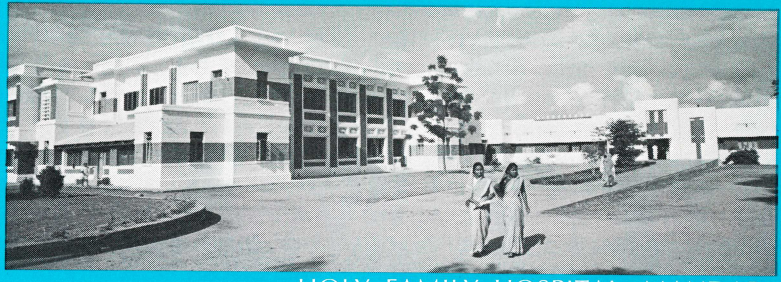
For a real servant of the sick, the patient's fear, questioning, puzzlement, reactions to new experiences, are far more accurate labels of his need than the diagnosis on his chart. The illness will be treated and forgotten, but the *manner* of healing leaves its mark.

HOLY FAMILY HOSPITAL, KARACHI, WEST PAKISTAN

FOR A WORK OF

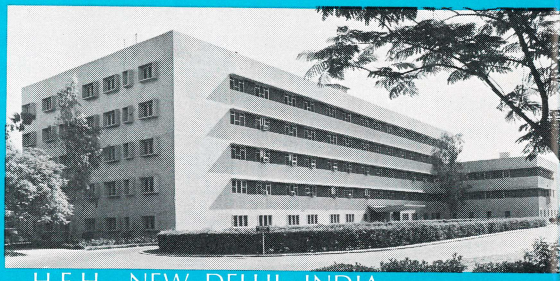
For a work of service

OUR LADY OF COROMOTO HOSPITAL, MARACAIBO, VENEZUELA

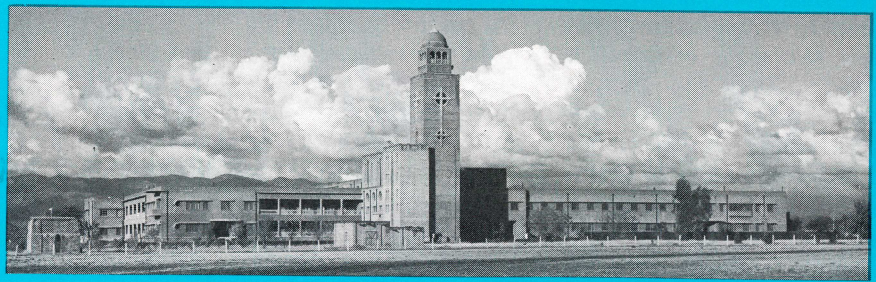


HOLY FAMILY HOSPITAL, MANDAR, INDIA

For building up the Body of Christ



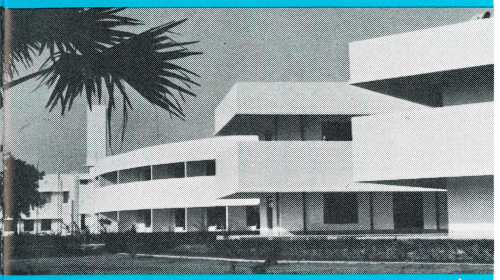
H.F.H., NEW DELHI, INDIA



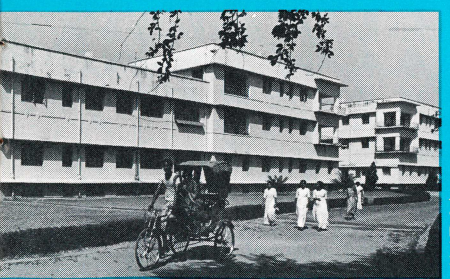
HOLY FAMILY HOSPITAL, RAWALPINDI, WEST PAKISTAN

SERVICE, FOR BUILDING UP THE BODY OF CHRIST

H.F.H., DACCA, EAST PAKISTAN



FOR THE HONOR AND GLORY OF GOD AND THE CAUSE OF SUFFERING HUMANITY



HOLY FAMILY HOSPITAL, PATNA, INDIA

This manner is of intense concern. In a well run hospital, the patient's initial insecurity soon gives way to confidence and a sense of human worth and growth.

This could be and often is his first real experience of community on a wider scale, this encounter with patients and professionals all striving for the same end. He comes to realize that he is central to a whole gamut of services. He begins to see how many people's lives are service-orientated. He has some experience of real dedication. He sees need as close as the next bed, is almost forced to contemplate it. He sees it met by human skill and genuine concern, and his attitude becomes increasingly positive and open. He participates in a great deal of exchange, both verbal and non-verbal, with fellow patients and staff. Philosophies of life and death and suffering, child-raising theories and methods, marriage and ethical values, religious beliefs, understanding of people and all their problems and the differences between them, all these become points of debate. Nothing brings one closer to essentials or provokes more thought than the problems that are part of the air a hospital breathes, problems of life and death and the struggle for existence.

Every mission hospital is a meeting place, of all kinds and classes of people, of old ways and new ways, of village and city, rich and poor, responsibility and helplessness, Christian and non-Christian. As such it is full of life, for "all

real living is meeting" (Buber), and it is heavy with the responsibility of a great human potential.

Training is another huge field of opportunity connected with hospitals, especially in the emerging nations. Mission hospitals make a notable contribution to the efforts of these nations to raise the number and quality of doctors, nurses, midwives and paramedical personnel. Teaching goes on in every department, teaching that by its very nature involves communicating values as well as techniques. Besides the student nurses and midwives, the aides and supervisors, there are interns and residents, there are the technicians in the laboratory, X-ray and pharmacy. Even the clerical workers and maintenance staff have their in-service training programs. Many of these people will multiply the impact of their training by communicating it in their turn. The number of patients cared for by any one person in our hospitals is bound to be small, in comparison to the statistics of the country, but who can guess how many human lives will eventually be happier and healthier because of the chain of training that is started there. And along with the training they will inevitably communicate the attitude toward the patient, and the human values they absorbed in their own training; values such as responsibility, dedication, human sensitivity, integrity and the dignity of humble service. Hospitals and good hospitals are indispensable to this work of training.

As it increasingly takes root in its environment, a mission hospital has a growing impact on it. A whole complex of opportunities arise from the hospital's presence: the opportunity to respond to requests to help set up village health programs, supervise outlying dispensaries, participate and exercise leadership in national professional associations, meet visitors from all parts of the world who come to the hospital, provide employment for the people of the area, contribute to the improvement of the standard of living, develop a sense of community among the employees and staff, encourage social responsibility by providing opportunities for volunteer workers. The list could be extended. In developed countries all this is incidental and commonplace. But in the newly developing countries these are pioneer efforts with far-reaching repercussions.

Only the many Sisters and people who have worked long and hard getting mission hospitals on their feet could know just how much they claim of initiative, energy and generosity, teamwork and responsiveness to the needs of people and environment. Nothing but a deep conviction that they stand for something worth all this and more could have brought them about.

Every mission hospital stands as a relevant sign of healing and of hope, a sign of authentic love in Christ for all the people of the earth.

that they may have life

BY SISTER M. PIERRE

"Oh, what a night! The old gentleman with liver cirrhosis died about midnight. Doctor Taj was there in plenty of time but the relatives were really hard to handle. Then, Raj Sultana decided to have her baby before I could take a breath, so I dashed up to the delivery room to take care of her. It was worth the dash though—what a beautiful baby she had! An 8-pound boy, so full of life, and she's like a changed woman. But Doctor, your post-operative patient in Room 234, Mirza Beg, isn't doing so well. I am afraid that there is not much life in her. Early this morning she grew very restless and I called Doctor Jahan. The doctor is with her. You might want to check in on them before you start morning rounds. . . ."

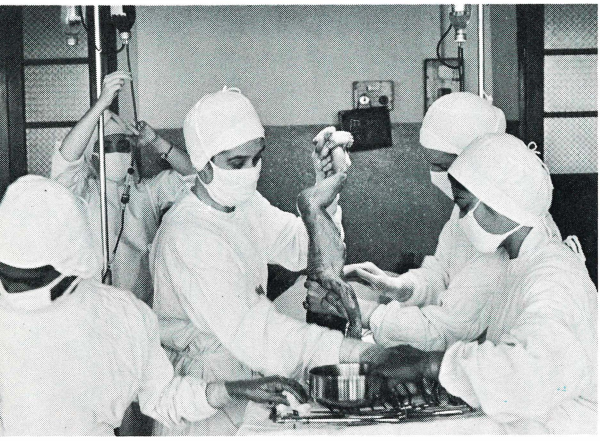
Any morning of the week—in fact, every morning of the week—fifty-two weeks of the year, this sort of report by the Sister who winds up a long night of duty, is routine at Holy Family Hospital. Within the walls of a mission hospital, life and death are so much a part of each day and night, so much in the air that is breathed, in the talk that is heard, in the thinking and praying of those on the staff, that they might even be called routine matters.

Life and death . . . routine matters. Not routine in the sense that they are regarded lightly, that people have grown casual about them. But routine with the meaning that more often than not, from moment to moment almost, life and death are there in front of you, having to be faced, contended with, answered for, fitted into a pattern.

Most mission hospitals can describe themselves quite accurately as existing "in a world of great

life

Sister M. Paul, M.D., and the delivery room staff stand face to face with the mystery of new life at H.F.H., Patna, India.



need." Not many patients come just for a doctor's check-up or a preventive inoculation. On the contrary, their needs are urgent and pressing, often extreme. A mission hospital's doors open and close on a long, continuous line of men, women and children, gasping, bedraggled, exhausted, often sick unto death. Their very presence demands an immediate response.

Many of those who come have walked miles, some have ridden a donkey or a bullock cart, a horse or a camel. Every day some are carried in on makeshift stretchers. The majority seem to have so little of life, so much about them of death. This explains the sense of urgency in the air within the hospital walls. The staff knows from the experience of yesterday and the day before that they are dealing right now with vital concerns. There is no time for non-essentials. Life and death hang in the balance.

Outside the same hospital, on the banks of the Ganges, a hindu widow mourns.

+ death

The reaction of the hospital staff to these patients in serious need is to grab hold with both hands, to leave no stone unturned in their saving efforts. For, to a Christian, life is pure gift and pure gold, held sacred, precious, not to be toyed with or handled cheaply. Did not the Lord God Himself come to our earth that men might have life and life in abundance?

But one thing a mission hospital learns very quickly is that life and death mean different things to different people. A woman is brought into the emergency room—critical—and the whole hospital converges its attention and skill toward this life, turning itself upside-down in an effort to save. The husband is asked to donate his blood as a life-saving measure. His reply, "It

is easier to get another wife than to put so much into trying to save this one." Ignorance and abject poverty, a survival existence, partly explain this reaction, but to a Christian, it comes with a starkness and callousness that strike deep.

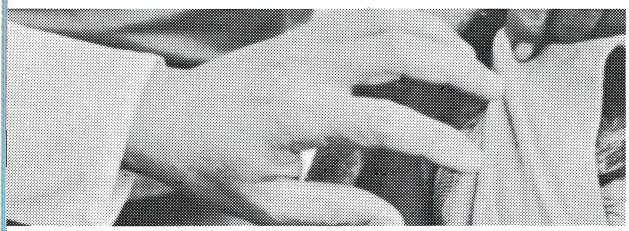
Or, again, the patient himself believes that this present life is just one particular existence in a continuous wheel of living. Dying means beginning again another weary round of life, perhaps on a higher scale depending upon one's merits, perhaps in a much lower form of life. Why fight so hard to preserve this life if the next one on the wheel might be less tedious or just as probable, more burdensome still? And every doctor and nurse knows that when the patient himself loses his fight, gives up inside, no medical means can restore him. If the spirits have ordained otherwise or Allah's intractable will has determined this hour, then too, before these deep-seated beliefs modern medicine bows its head in defeat. Quite literally, people can be helped beyond a certain point only if they believe and believe deeply that "life *is* worth living."

It is one thing to read statistics stating the average life expectancy in Asia is 35 years, but for a mission hospital to exist in a society where there are relatively few old people just because not that many have had the physical stamina, the endurance, to battle disease and illness year after year after year, is to see the "gift" of life with new eyes. The young student nurses at Holy Family Hospital have an instinctive respect for the old people among their patients, acknowledging almost without knowing they are doing it, the feat of these old people in just having hung onto life for so many years. Death's early arrival for many, explains perhaps the great joy, the overwhelming reception with which these same people greet new life. In this newborn infant lies the potential, however delicately balanced, of a long, productive future, and hope is born anew in the eyes and hearts of the onlookers.

In another milieu, among animists on the West African coast, if a pregnant woman dies, the entire family is held in disgrace, since the assumption is that her death resulted from unfaithfulness to her husband. In this situation, the arrival at a mission hospital of a seriously ill woman who is with child sets off an immediate signal for every available medical skill to be concentrated on her. More is at stake here than just one life.

On the other hand, among these same people, when death has occurred in the hospital, there is no question of their blaming the doctor or nurses. "You have done your best," they say, "You have tried." Death is no stranger to them and has found its place in the structure of their every day.

All men have lessons to learn, words whose meaning they must penetrate. Some of these lessons are small ones, taken easily in stride. But life and death are different. They are big words in any man's vocabulary. To deal intimately with them through the day, the night, this month, this year; to be greeted constantly with "Will she live, Sister? Has my father died yet? How much longer do you think she has? When did my wife give birth, Sister?"—makes a mission hospital come to maturity overnight.



It was my

The night nurse whispered outside my mosquito net, "Sister, they have just brought in a patient from another village. She's been in labor since yesterday and she doesn't look too good. Please come quickly." I looked at my watch. It was 2:00 A.M.

As I hurried downstairs I could hear a woman moaning. Since women in this area seldom make any noise during a normal or even difficult labor, the moaning had an ominous sound. The patient joined her hands together, Indian style, and smiled wanly as I came near. Rukmani had little to smile about. There were all the signs of an impending rupture of the uterus. We moved quickly, called the doctor, set up the operating room, "prepped" the patient. In a very short time, Rukmani was on the O.R. table.

In spite of moving as fast as we did, the uterus had ruptured by the time the doctor started the operation. Rukmani rapidly sank into shock from the profuse blood loss, and her baby was dead. From here on it was a fight to save the mother's life.

She needed blood urgently to replace what she had lost. This is not as simple as it sounds, in an area where anemia is the usual, and a donor once found, is often able, but not willing to give. To add to our problems, Rukmani's type was not a common one. Finally, after much searching, persuasion and argument, we did get two donors and enough blood to begin a transfusion.

By this time, however, Rukmani's blood pressure was so low, her veins were beginning to collapse. Luckily, we did get the needle into her brachial vein but couldn't increase the pressure enough within the transfusion bottle to force the blood through the veins. We ended up disconnecting the transfusion set and giving her the full two pints of blood and a bottle of plasma, a syringeful at a time into her vein. It was a long, tedious process and I had to stop periodically to uncramp my fingers.

After many hours, Rukmani flickered her eyelids, gave me a weak smile and attempted to join her hands in the traditional Indian greeting. I quickly intercepted this movement fearing she would displace the needle in her vein, but I

privilege

BY SISTER M. SUZANNA

had to smile at the ingrained courtesy of this village woman, who would join her hands in greeting as her first conscious act after having knocked hard at the gateway to eternity.

It was almost midnight when I climbed back into bed after a long, long day that had begun at 2:00 A.M. with Rukmani's arrival. But it was with the warm feeling, composed partly of experience and partly of intuition, that says, "This patient will make it."

The next day Rukmani was already much better. To my embarrassment, I discovered that the relative who had stayed with the patient informed her husband that Rukmani started getting better after I knelt down by the side of the bed and prayed. The fact of the matter is, I was so tired I knelt down to steady my arm against the edge of the bed. If I said a prayer, it was something like, "O God, please let me stay in the vein."

In a couple weeks Rukmani was ready to go home. Thanks to the blood transfusions, injections and medicines, she was less anemic than she had ever been in her life. She came to say good-bye to me and started to bend down to kiss my feet. This is a gesture of profound respect and gratitude in the East, but one which I've never felt equal to accepting. I caught her about halfway down and she kissed my hands instead.

It was no routine gesture. She kissed my hands very slowly and respectfully. Somewhat awed, I said, "Rukmani, these are really very ordinary hands to be kissed so reverently." She looked up and very politely, but firmly, corrected me. "No, Sister, these are the hands of Christ!" A little astounded at this answer from a non-Christian, I asked, "Rukmani, what do you think the hands of Christ were like?" She replied, "They were kind and they were skilled."

If I wanted to sum up my vocation, I don't think I could come up with a better answer than this Hindu woman's—to be the "hands of Christ." When Rukmani gave me her final thank you, there was really only one reply I could make, "It was my privilege."

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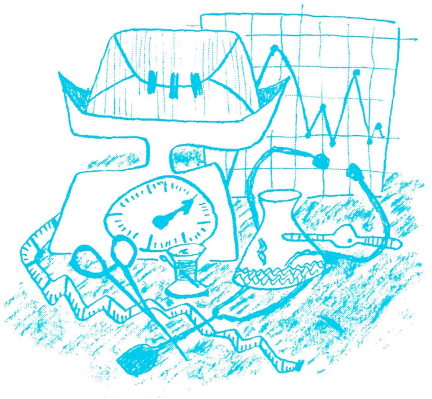
NOTES from our houses

GHANA

Saint Joseph the Worker

I just want to tell you about our celebration for the Feast of St. Joseph the Worker. Sister M. Fernande arranged to have the office staff mimeograph some Twi and English hymns for Mass. The day before the feast, Sister and I took the employees for practice. Kwaw, the carpenter, joined the laundry boys and we began in earnest. Because everybody was so busy, we could only take about ten minutes. Finally, Kwaw said, "But, Sister, how can we make the singing sharp sharp in such a short time unless we start four days ago?" You see, Kwaw is a chorister in the Methodist Church. Anyway, I said we all must try. While I was explaining the feast and telling everybody to bring an implement of his work to be blessed, Atta Grushie, a Mohammedan, popped up with, "Who is St. Joseph?" Well at that, Michael, not having any patience with him, said, "You know, the Father of Jesus, Mary's husband."

We placed the large statue of St. Joseph up in front of chapel and arranged flowers and a piece of kente cloth around it. We had a sung Mass facing the people and, sure enough, most of the employees came. Edward from the OR brought up a pack of instruments and placed them at St. Joseph's feet. Mama, a ward boy and catechumen, brought his broom; John from central supply, his field sterilizer; Michael the tailor, his scissors and measuring tape; the laundry boys, their brushes; Miss Martey, the student in the nursery, the baby scale, Kwaw the carpenter, his saw; Kakraba the mason, his measuring tape; the lab boys, Fabiano and Albano, their pipettes; Sister Fernande, her stethoscope; the student nurses, their scissors and pans; and myself, the fetuscope. After Mass, Father blessed the implements, using a palm branch to sprinkle the holy water. Before beginning the prayers, Fa-



ther made sure it was understood that this was not some kind of ju-ju. Everyone smiled at this. Then he gave a short talk about the value of work. The hymn at the end, *"Mbo Joseph kronkron mbo,"* nearly took the roof off.

Sister M. Laboure
Holy Family Hospital, Berekum

EAST PAKISTAN

Tragedy in Dacca

The cyclone and tidal wave that swept over eight districts here in East Pakistan, May 11th and 12th, claimed thousands of lives and left an estimated seven million people homeless. In Dacca city itself, about 80% of the small bamboo houses were completely demolished in the worst storm in the memory of living men in this part of the world. It started about 11:00 P.M. with heavy rain, thunder and wind. In my somewhat limited experience of not quite six months, I had not seen anything quite so enthusiastic as this downpour but supposed it was the "monsoon" everyone keeps telling me about. The first seed of doubt crept into my mind when, despite closed windows, my bed was getting damper and damper. The second seed of doubt came after I got out of bed and found myself a little more than ankle deep in water. On my way downstairs I could see the overturned, overblown houses, our own brand new brick wall completely destroyed and the tin roof of our laundry shed jauntily perched on the top of the storage house.

The electrical wires were all down, so that meant our water pump didn't work, no autoclave, no burners for cooking in the kitchen. Everyone turned to emergency measures: a bucket brigade to get water from the roof, meals cooked over an open fire and, to top it off, an emergency Caesarean Section by kerosene lamp and flashlight. Thank God, the baby arrived safely, a lovely boy, completely unconcerned with the storm raging around him. We anticipate a series of epidemics in the wake of this tragedy.

Sister Elizabeth Marie
Holy Family Hospital, Dacca

VENEZUELA

A Note From the Bishop

On the feast of the Sacred Heart, Bishop Antonio Jose Ramirez of Maturin came to Caripito to participate in our parish festivities. As usual he came over to the hospital to say "hello." As he was sitting in the parlor talking with some of the Sisters, he noticed our small harmonium behind the door and asked us if we played it. When

we told him that one of the essential notes did not play, he began to try it out. After a few minutes he remarked that the note was easy to fix and requested a screw driver, pincers, tweezers, test tube brush and razor blade. Within fifteen minutes the minor operation was completed, and our Bishop showed us how well he could play a harmonium.

Sister M. Mercedes
Holy Family Hospital, Caripito

INDIA

Light and Darkness

I must tell you about our Maundy Thursday evening. We will remember it for a long time. We planned to have our Agape (festive meal) in the evening before Holy Mass. Shortly before mealtime, Sister M. F. Monica came running to me, calling: "The kerosene oven in the kitchen is on fire!" Sister Benet and I rushed to the kitchen but we could not move the oven or turn it off. In no time the fire was raging and we were sure we would never be able to put it out. We called the Fire Brigade while the novices and postulants brought gravel and sand to throw over the fire. Fortunately, we were able to disconnect the gas stoves and move the gas tanks. The fire had just subsided when the Fire Brigade followed by the police and half our Bibwewadi village appeared on the scene, a full twenty-five minutes later. We looked a sight—worse than chimney sweeps! These men really got a big kick out of it all and as the police left they said, "We are glad we came. At least we got to see you and your house." The kitchen was in worse shape than we were. The men are still at work scraping soot and paint off the walls. It is not an easy job and will take at least two weeks. Meanwhile, we are cooking outside on coal stoves.

After the Fire Brigade left that night, we managed to recover from the excitement and go on with the Maundy Thursday liturgy celebration. The Mass was really beautiful. For the first time we had it facing us. We had concelebration and four servers, two of whom were dressed in real Brahmin style, that is, with red *dhotis* (long cloths) and white shawls thrown over their shoulders. During Mass we had another minor crisis, no electricity. The main supply was cut off that night because there had been a storm. The darkness only added to the beauty of the celebration. In fact, when the lights came on toward the end, everyone was a little disappointed.

Sister M. F. Margaret
Poona Novitiate

Pope Paul expressed his esteem for the thousands of nuns dedicated to nursing the sick throughout the world. During a talk in St. Peter's before the delegates to the Third Congress of the Italian Federation of Nursing Sisters the Holy Father said:

"Your solicitous and intelligent presence, your delicate and maternal presence at the side of those who suffer is the best demonstration that the Catholic religion, and in particular the consecration of oneself to God in religious life, is not a useless and harmless renunciation nor a negation of the healthy values of the personality.

"It is not a cowardly and fearful rejection of the responsibilities of active employment in the service of your brethren. It is a gift, the offering of oneself, a loving answer to God which overflows in the service of our fellow human beings."

Pope Paul VI
THE ADVOCATE, April 29, 1965

The fact is that Vatican II planted the seeds for a new growth in Christian life by issuing the Constitution on the Liturgy at its first session. And with the proclamation of *De Ecclesia*, it has left little room for doubt that the mission of the Church is the total responsibility of all the members of the Church. One author summed it up by saying that Vatican II has taken the "s" out of missions, showing the mission of the Church to be one. It is shared by all and cannot be divided into obscure regions on the other side of the globe. Wherever Christ is not, the mission of the Church must be. The mission is not entrusted just to a few groups or societies within the Church, it belongs to all.

THE WORLD PARISH
(Maryknoll Fathers)
April, 1965

"There are so many sick people needing to be treated, so many eager and willing people needing to be trained, so many countries just getting started, needing to be strengthened. There is a world needing so desperately to be healed. Thank God there are so many in our profession who want to give their best to do this job."

Walter Judd, M.D.
AMA Conference on International Health
November, 1964

"The human being creates the perfection of his own being by being open to others. Human life is the substantial opportunity to embody self in the service of community. Therefore, every authentically human act is an act of self-giving."

Paul Barrett, O.P.
NEW BLACKFRIARS, Feb.. 1965

"One priest for every 1,000 inhabitants—this is the ideal proportion between clergy and faithful, according to the finding of the Congress of Ecclesiastical Vocations two years ago. However, this minimum does not exist in any country except Canada.

In the United States, the proportion is one priest for every 1,211 Catholics. In the archdiocese of Bogota in Latin America there are 167 priests for 2,000,000 inhabitants, a total of 11,976 Catholics for each priest. In Africa, there is one priest for every 10,000 inhabitants, and in the rest of Latin America the proportion is alarming. Haiti lists one priest for every 9,000 Catholics; Guatema, one for every 16,000; Jamaica, one for every 21,000. In the diocese of Sao Paulo (Brazil), only two new priests were ordained during the same period that 60,000 new Catholics were baptized!"

CIDOC NEWS, Oct. 7, 1964

"On the surface there seems to be a contradiction between death to the world and the contemporary Christian emphasis, so strongly underlined by the Vatican Council, demanding our involvement in the world. Dying to the world, however, does not mean becoming otherworldly, withdrawn from reality or turned away from our social existence as men. Rather, it must mean for the contemporary Christian our willingness to repent of our selfishness and to detest the destructive forces in us making us a stranger to our neighbor and hostile to the will of God.

"A new ideal of holiness is emerging in our age. Today, the following of Christ means to acknowledge more consciously that we serve His mission to reconcile the human family and to transform the world."

Most Rev. Philip F. Pocock,
Archbishop of Toronto

YOUR WILL

Your will can help the Medical Mission Sisters bring Christlike charity through their medical work to areas of greatest need around the world. The following approved form of bequest may be used:

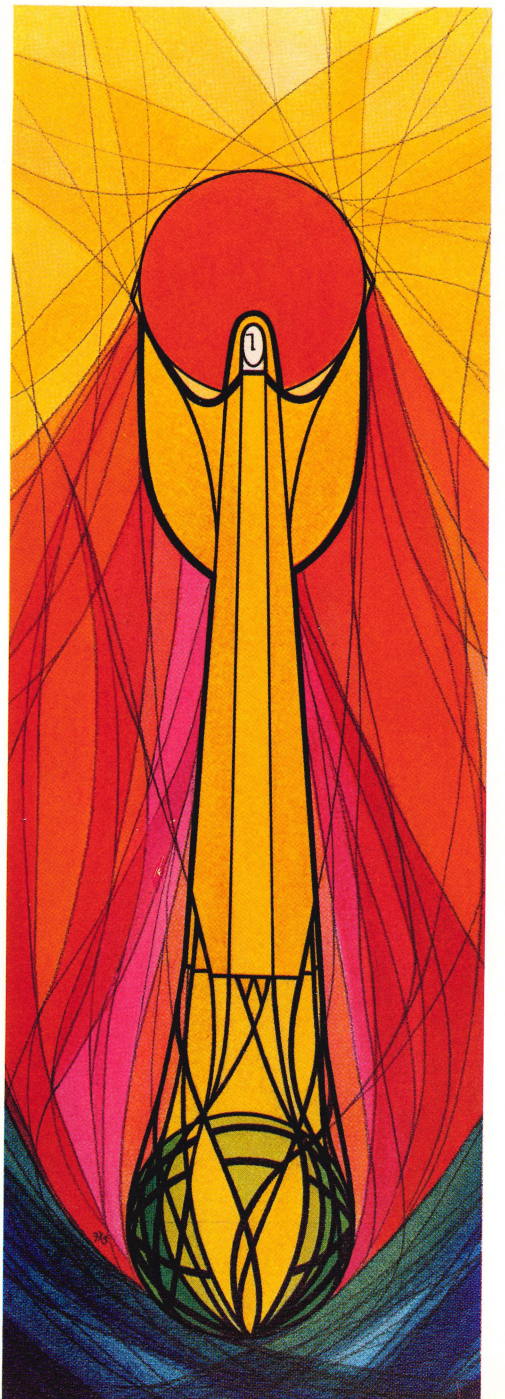
"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $_____ for its purposes."

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.

THE ASSUMPTION

man is made for heaven
authentic sign?
one woman burst the bonds that held her here
again we choose
to bid her many daughters
spread the news

Sister Miriam Therese S.C.M.M.



and now we find we have nothing on ice! Holy Family Hospital, Bombay, India, needs a deep freeze— and some ice boxes. Please help!"

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Philadelphia 11, Pa.